Provider Synergies, an affiliate of Magellan Medicaid Administration,

Virginia Medicaid's Pharmacy Service Administrator

Phone: 1-800-932-6648 Fax: 1-800-932-6651

General Information:

- The PDL is a list of preferred drugs, by select therapeutic class, for which the Medicaid Fee-for-service program allows payment without requiring service authorization (SA).
- *Please note that not all drug classes are subject to the Virginia Medicaid PDL*. In the designated classes, drug products classified as non-preferred will be subject to SA. In some instances, other additional clinical criteria may apply to a respective drug class which could result in the need for a SA.
- This is list is not all inclusive for non-preferred drugs.
- Fax requests receive a response within 24 hours.
- For urgent requests, please call **1-800-932-6648.**
- Not all medications listed are covered by all DMAS programs. Check individual program coverage.
- All new products included in a PDL class are non-preferred until reviewed by the P&T Committee.

For PDL drug coverage information, visit the following: http://www.VirginiaMedicaidPharmacyServices.com. **The following "routine" PDL criteria guidelines will be applied to non-preferred drugs requiring a Service Authorization. Some drug classes will have additional criteria that will be listed alongside the drug class.**

1. Is there any reason the patient cannot be changed to a medication not requiring service authorization within the same class?
   Acceptable reasons include:
   - Allergy to medications not requiring service authorization
   - Contraindication to or drug-to-drug interaction with medications not requiring service authorization
   - History of unacceptable/toxic side effects to medications not requiring service authorization
   - Patient's condition is clinically stable; changing to a medication not requiring service authorization might cause deterioration of the patient's condition.

2. The requested medication may be approved if both of the following are true:
   - If there has been a therapeutic failure of no less than a **one-month trial** of at least **one** medication **within the same class** not requiring service authorization
   - The requested medications corresponding generic (if a generic is available and covered by the State) has been attempted and failed or is contraindicated.

All changes from last posting will be highlighted in yellow.

Teal highlights indicate where a Brand is preferred over a generic

Drugs no longer available have been removed from this list.

Preferred Agents	Non-Preferred Agents	SA Criteria
Analgesics		
Narcotics – Long Acting (LAN)		

fentanyl patch
Kadian® ER
***methadone 10 mg/5mL & 5mg/5mL oral soln**
***methadone 5mg & 10mg tab**
morphine sulfate tab SA
	Avinza®
	Butrans®
	Conzip ® ER
	**Dolophine®*
	Duragesic®
	Embeda®
	Exalgo®
	**Methadose®*
	morphine ER (Avinza®)
	morphine ER (Kadian®ER)
	MS Contin®
	Nucynta® ER
	Opana® ER
	Oramorph ® SR
	oxycodone-long acting
	OxyContin®
	oxymorphone ER
	Ryzolt™
	tramadol ER
	Ultram ER®
	Xartemis™ XR
	Zohydro ER™
		LENGTH OF AUTHORIZATIONS:
		• Up to 6 months after trial and failure of 2 different short acting narcotics **OR**
		• Up to one year for cancer and sickle cell **OR**
		• One to three months for chronic non-malignant pain
		
		Clinical Criteria for LAN
		• If diagnosis is chronic non-malignant pain they must have :
		  ○ A treatment plan that includes a diagnosis & goals of therapy.
		  ○ Documentation of provision of an assessment of addiction risk with the therapy.
		  ○ Attestation from prescriber that the Virginia Board of Pharmacy Prescription Drug Monitoring Program database has been recently reviewed
		  ○ Be aware of the request for possible random urine drug testing
		  ○ A pain management contract that addresses the following:
		  ▪ The consequences of unexplained loss or shortage of medications
		  ▪ The consequences of obtaining similar prescription medications from other prescribers;
		  ▪ An agreement with the patient to only use one pharmacy.
		
		Additional PDL edit
		• Approval of non-preferred agents in this class requires:
		  ○ Contraindication to all PDL preferred agents, or
		  ○ drug to drug interaction to all PDL preferred agents, or history of toxic side effects from all PDL preferred agents that cause immediate or long-term damage (NOTE: this does not include GI intolerance) with ALL preferred agents
		
		***Clinical Criteria for Methadone**
		All methadone agents receive a clinical edit to determine reason for use. Low dose strengths are generally used for pain. Please see criteria for clinical edit for methadone 40mg dispersible tablets and 10mg/mL oral concentrated solution for detoxification and maintenance treatment of narcotic addiction.

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Narcotics – Short Acting		
Barbiturate & Non-Salicylates Analgesic Combinations		**LENGTH OF AUTHORIZATIONS:** 3 months **Routine PDL edit plus** **Clinical Criteria for narcotic lozenges** • Diagnosis of **breakthrough cancer pain** • Patient is receiving around-the-clock scheduled long-acting narcotics; AND • Patient is receiving and tolerant to other opioids as indicated by one of the following: o At least 60 mg of morphine per day for at least one week without adequate pain relief; OR o At least 25 mcg/hr of transdermal fentanyl for at least one week without adequate pain relief; OR o At least 30 mg oxycodone per day for at least one week without adequate pain relief; OR o At least 8 mg hydromorphone per day for at least one week without adequate pain relief; OR o An equianalgesic dose of another opioid for at least one week without adequate pain relief; AND • Patient has tried and failed at least two immediate release opioid products (e.g., oxycodone, immediate-release morphine, hydromorphone) for breakthrough pain OR has a contraindication, intolerance, or drug-to-drug interaction with at least two immediate release opioid products
acetaminophen-butalbital	*Orbivan CF®* *Phrenilin Forte®* *Sedapap*	
Lozenges - Narcotic		
	Actiq® *Fentora®* *fentanyl citrate* *Onsolis®*	
Opioid Dependency - Methadone products		***Clinical Criteria for methadone 40mg dispersible tablets & 10mg/mL oral concentrated solution** • FDA approved ONLY for detoxification and maintenance treatment of narcotic addiction • Patient must be enrolled in a methadone treatment program (opioid treatment program, OTP) • Dispensed only by opioid treatment programs (and agencies, practitioners, or institutions by formal agreement with the program sponsor) certified by the Federal Substance Abuse and Mental Health Services Administration and registered by the Drug Enforcement Administration (DEA).
*** Diskets® 40mg** *** methadone 10mg/mL Intensol oral concentrated soln** ***methadone 10mg/mL oral concentrated soln** ***methadone 40 mg** ***Methadose®10mg/mL oral concentrated soln** ***Methadose®40 mg**		

Preferred Agents	Non-Preferred Agents	SA Criteria
Opioid Dependency - Buprenorphine products		****Clinical Criteria for buprenorphine SL, buprenorphine/naloxone tablets, Suboxone® SL/Film, & Zubsolv™** • Diagnosis of opiate abuse/dependence. • Prescribed by a qualified prescriber who has o A Substance Abuse and Mental Health Services Administration Waiver and has o An active "X" DEA number AND o The prescription is written under the "X" DEA number such that this patient counts toward the patient limits established for individual prescribers by the DATA 2000 waiver. • The prescriber has reviewed the Virginia Controlled Substance Database. • Patient is receiving addiction counseling. • A chemical dependency assessment has been performed AND • Criteria for chemical dependency are met. • Patient is 16 years of age or older (no exceptions allowed); AND • Patient is not pregnant (Suboxone® SL/Film, buprenorphine/ naloxone, and Zubsolv). ~~• Max duration is 24 months~~ • Max dose is 16mg/day Suboxone®. Zubsolv™ Quantity Limit = 68 tablets / 34 days
****buprenorphine SL** ****Suboxone®film** ***** naltrexone tablet**	***buprenorphine/naloxone tab* ***Zubsolv™*	
		*****Clinical Criteria for naltrexone oral** • Must have a diagnosis of o Alcohol dependence **OR** o Opioid dependence ▪ Do not attempt treatment with naltrexone unless, in the medical judgment of the prescriber, there is no reasonable possibility of opioid use within the past 7 to 10 days. If there is any question of occult opioid dependence, perform a naloxone challenge test.
Short-Acting Narcotics		**Revised from routine PDL edit short acting narcotics** • Approval of non-preferred agents in this class requires: o Contraindication to all PDL preferred agents, or o Drug to drug interaction to all PDL preferred agents, or
codeine/APAP **codeine/APAP/caff/butal** **codeine/ASA**	*All Brands require a SA* *Abstral®* *codeine tab/soln*	

	Preferred Agents	Non-Preferred Agents	SA Criteria
	codeine/ASA/caff/butal **hydrocodone/APAP** **hydrocodone/ASA** **hydrocodone/ibuprofen** **hydrocodone bitartrate/APAP** **hydromorphone** **morphine IR** **nalbuphine** **oxycodone IR** **oxycodone/APAP** **tramadol HCL**	*butalbital comp with codeine* *butorphanol tartrate nasal* *dihydrocodeine/APAP/caffeine* *dihydrocodeine/ASA/caffeine* *hydromorphone liq/supp* *meperidine tab* *Nucynta®* *Oxecta®* *oxycodone/ASA* *oxycodone/ibuprofen* *oxymorphone HCl* *pentazocine/naloxone* *PrimLev™* *tramadol HCL / APAP* *Ultracet®* *Ultram®* *Zydone®* *Zolvit®*	○ History of toxic side effects from all PDL preferred agents that cause immediate or long-term damage (NOTE: this does not include GI intolerance) with ALL preferred agents
	Non-Steroidal Anti-Inflammatory Drugs		
	Children's ibuprofen susp (OTC) **ibuprofen (OTC & RX)** **Infant's ibuprofen drops susp OTC** **meloxicam tab** **nabumetone** **naproxen** **naproxen sodium** **piroxicam** **sulindac**	*Anaprox® IR & DS®* *Advil®* *Aleve®* *Ansaid®* *Arthrotec®* *Cataflam®* **Celebrex®* *Clinoril®* *Daypro®* *diclofenac potassium* *diclofenac sodium SR* *diclofenac sodium/misoprostol* *diflunisal* *Dolobid®* *Duexis®* *etodolac IR & SR*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit plus** A one-month trial of at least two preferred medications within the same class. ***Step edit required for Celebrex®** • History of a trial of a minimum of two (2) different non-COX2 NSAIDs within the past year**,** OR • Concurrent use of anticoagulants (i.e., warfarin, heparin, etc.)**,** methotrexate, oral corticosteroids, OR • History of previous GI bleed or conditions associated with GI toxicity risk factors (i.e., PUD, GERD, etc.), OR specific indication for Celebrex®, which medications not requiring Service Authorization are not indicated.

Preferred Agents	Non-Preferred Agents	SA Criteria
	Feldene® *fenoprofen* *flurbiprofen* *Indocin®IR & SR®* *indomethacin IR, SR & rectal* *ketoprofen IR & ER* *ketorolac* *Lodine®IR & XL* *meclofenamate* *mefenamic* *meloxicam susp* *Mobic®* *Motrin®* *Nalfon®* *Naprelan®* *Naprosyn®* *naproxen EC* *Orudis®* *Oruvail®* *oxaprozin* *Ponstel®* *Prevacid Naprapac®* *Relafen®* *Sprix® nasal spray* *Tolectin DS®* *Toradol®* *tolmetin sodium* *Vimovo®* *Voltaren® IR & XR* *Zipsor®* *Zorvolex™*	
Topical Analgesic Agents and Anesthetics		
***Flector® patch** ***Voltaren® gel**	***Lidoderm® patch* ***lidocaine 5% patch* **Pennsaid® top soln &pump* ****Solaraze 3% Top Gel*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit** ***Clinical Criteria for Topical Analgesic Agents and Anesthetics** ➢ ***Flector®, Voltaren® & Pennsaid®:**

Preferred Agents	Non-Preferred Agents	SA Criteria
		• Approval is based on patient failing the oral generic of the desired product and at least one other preferred NSAID (to equal a total of at least two preferred). For example, a patient who failed ibuprofen or naproxen will still need to try oral generic diclofenac for approval of Flector®. • Pennsaid® can only be approved for the FDA approved indication of osteoarthritis of the knee. • Quantity limit for Flector® Patch; 30 patches per RX ➢ **<u>Lidoderm® Patch:</u> • Lidoderm® patches can be approved for relief of pain associated with post-herpetic neuralgia. ➢ ***<u>Solaraze® 3% Gel Clinical Criteria</u>: • Indicated for the topical treatment of actinic keratosis (AK). • Sun avoidance is indicated during therapy. • Precautions exist for patients with active GI ulceration or bleeding and severe renal or hepatic impairment
Antibiotic-Anti-Infective		
Antibiotics, Inhaled		
Tobi® ***Tobi Podhaler®**	*Bethkis®* *Cayston®* *tobramycin inhalation nebulizer sol*	<u>**LENGTH OF AUTHORIZATIONS**</u>: 1 year **Routine PDL edit plus** **Clinical Criteria for Antibiotics, Inhaled** ➢ ***Tobi Podhaler®** (tobramycin inhalation powder) • Tobi® nebulizer 300mg/5 mL solution is covered without SA; clinical reason as to why Tobi® nebulizer 300mg/5 mL solution cannot be used. • Minimum age restriction of 6 years of age. ➢ **Cayston® and Bethkis®** • Diagnosis of cystic fibrosi.s • Previous therapy with tobramycin via nebulizer. • Demonstration of TOBI® compliance. **Quantity limits** Tobi® = 8 capsules per day Cayston® = 84mL per 28 days

Preferred Agents	Non-Preferred Agents	SA Criteria
		Bethkis® = 56 ampules per 28 days
Antibiotics, Vaginal		
Cleocin® Ovules **Metrogel®** **Vandazole™ gel**	*Cleocin® cr* *Clindesse ®cr* *clindamycin cr* *metronidazole gel*	**LENGTH OF AUTHORIZATIONS**: Date of Service **Routine PDL edit**
Antifungals, Oral		
fluconazole tab/susp **Griseofulvin ® susp** **Gris-Peg®** **ketoconazole** **nystatin tab/susp** **terbinafine**	**Ancobon ®* *clotrimazole (mucous mem)* *Diflucan® tab/susp* *flucytosine* *Grifulvin V® tab* *griseofulvin tablets* *griseofulvin ultramicrosize* *itraconazole* ***Lamisil ® tab/granules* ****Noxafil®* *****Onmel®* ******Sporanox® cap/soln* *Terbinex™ kit* *******Vfend® tab/susp* *voriconazole tab & Powder for Susp*	**LENGTH OF AUTHORIZATIONS**: Duration of the prescription (up to 12 months) **Routine PDL edit plus** **Clinical Criteria for Antifungals, Oral** ➢ **Ancobon®:** • Indicated for the treatment of : o **Candida:** Septicemia, endocarditis, and UTIs o **Cryptococcus:** meningitis, pulmonary infections • Can be approved if the patient has a serious illness that leaves them immunocompromised (i.e. AIDS, cancer, organ transplants). ➢ ****Lamisil® granules** • Indication is tinea capitis, **AND** • Must be over 4 years of age. ➢ ***** Noxafil®** • One of the following indications: o Used for preventative (prophylactic) therapy for treatment of invasive Aspergillus o Diagnosis of Candida o Patient is immunocompromised o Diagnosis of graft-versus-host disease (GVHD) o Patient has a hematologic malignancy (a cancer of the blood, bone marrow, or lymph nodes) o Patient has prolonged neutropenia from chemotherapy o Diagnosis of Zygomycosis o Diagnosis of Fusariosis o Patient has another fungal infection or mold infection is refractory or resistant to itraconazole or voriconazole, or patient has a contraindication to itraconazole or voriconazole

Preferred Agents	Non-Preferred Agents	SA Criteria
		➢ ****<u>Onmel®</u> • Indicated for the treatment of onychomycosis of the toenail caused by *Trichophyton rubrum* or *T. mentagrophytes*. • Patient had a therapeutic trial and treatment failure with oral terbinafine, **OR** • Patient has a contraindication to oral terbinafine (i.e. heart failure, hepatic impairment, viral hepatitis). ➢ *****<u>Sporanox®</u> • indication are Aspergillosis, Candidiasis (oral or esophageal), Histoplasmosis, Blastomycosis, empiric treatment of febrile neutropenia ➢ ******<u>Vfend®</u>: • Can be approved without failure on the preferred agent if the patient has any of the following diagnoses: o Myelodysplastic Syndrome (MDS), o Neutropenic Acute Myeloid Leukemia (AML) o Graft versus Host Disease (GVHD) o Candidemia (candida krusei) o Esophageal Candidiasis o Pulmonary or invasive aspergillosis o Blastomycosis o Serious fungal infections caused by *Scedosporium apiospermum* (asexual form of *Pseudallescheria boydii*) and *Fusarium* spp., including *Fusarium solani*, in patients intolerant of, or refractory to other therapy. o Oropharyngeal/esophageal candidiasis refractory to fluconazole. • Can be approved if the patient has a serious illness that leaves them immunocompromised (i.e. AIDS, cancer, organ transplants).
Cephalosporins, Oral		
Second Generation Cephalosporins		**<u>LENGTH OF AUTHORIZATIONS</u>**: Date of service only; no refills **Routine PDL edit plus** **Clinical Criteria for Cephalosporins** • Infection caused by an organism resistant to medications not requiring SA • A therapeutic failure to no less than a **<u>three-day trial of one medication</u>**
cefaclor cap **cefprozil cap/susp** **cefuroxime tab**	*cefaclor ER* *cefaclor susp* *Ceftin® tab/susp* *Cefzil® tab/susp*	

Preferred Agents	Non-Preferred Agents	SA Criteria
		within the same class not requiring SA • The patient is completing a course of therapy with a medication requiring a SA, which was initiated in the hospital.
Third Generation Cephalosporins		
cefdinir cap/susp **Suprax® tab/susp**	*Cedax® cap/susp* *ceftibuten* *cefditoren pivoxil* *cefpodoxime proxetil cap/susp* *Omnicef ® cap/susp* *Spectracef®* *Suprax®chewable tab* *Suprax® cap*	
Macrolides, Oral		
Macrolides & Ketolides		**LENGTH OF AUTHORIZATIONS**: Date of service only; no refills **Routine PDL edit plus** **Clinical Criteria for Macrolides and Ketolides** • Infection caused by an organism resistant to medications not requiring SA • A therapeutic failure to no less than a **three-day trial of one medication within the same class not** requiring SA • The patient is completing a course of therapy with a medication requiring a SA, which was initiated in the hospital *Generics are not available in some strengths/dosage forms **To receive a SA for Ketek®, a specific Ketek® SA request form must be completed and faxed or mailed to Magellan Medicaid Administration with the prescriber's signature.
azithromycin pack/susp/tab **clarithromycin tab/susp** ***E.E.S.®** ***EryC®** ***Eryped® 400 susp** **Ery-tab®** **erythrocin stearate** **erythromycin base** **erythromycin ethylsuccinate** **erythromycin estolate susp** **erythromycin stearate** **erythromycin/sulfisoxazole**	*Biaxin®tab/ susp/XL* *clarithromycin ER* *Dynabac®* ***Eryped®200 susp* *erythromycin base DR cap* ***Ketek®* *PCE®* *Zithromax® pac/tab/susp* *ZMAX® susp*	
Quinolones, Oral		
Second Generation Quinolones		**LENGTH OF AUTHORIZATIONS**: Date of service only; no refills **Routine PDL edit plus**: **Clinical Criteria for Quinolones** • Infection caused by an organism resistant to medications not requiring SA. • A therapeutic failure to no less than a **three-day trial of one medication within the same class not** requiring SA.
Cipro® susp **ciprofloxacin tab**	*Cipro®IR & XR* *ciprofloxacin susp & ER* *Noroxin®* *ofloxacin* *Proquin XR®*	

	Preferred Agents	Non-Preferred Agents	SA Criteria
			• The patient is completing a course of therapy with a medication requiring a SA, which was initiated in the hospital.
	Third Generation Quinolones		
	Avelox® ABC PACK **levofloxacin tab**	*Avelox®* *Factive®* *Levaquin® tab/susp* *levofloxacin susp* *moxifloxacin* *Proquin XR®*	
	Quinolones, Otic		
	Ciprodex® **ofloxacin**	*Cetraxal®* *Cipro HC®*	**LENGTH OF AUTHORIZATIONS:** Date of service only; no refills **Routine PDL edit**
	Topical		
	mupirocin ointment	**Altabax™* *Bactroban® cream/ointment* *Centany®* *Centany AT® Kit*	**LENGTH OF AUTHORIZATIONS**: Date of service only; no refills **Routine PDL edit** *Quantity Limit = 15 grams per 34 days
Antivirals			
	Hepatitis C Agents		
	Interferon		**LENGTH OF AUTHORIZATIONS**: refer to Clinical Criteria for each drug **Clinical Criteria for Interferon** **Initial 16 week SA**: Initial approval periods limited to 16-weeks and viral titer obtained at week 12 of therapy. **Established HCV reactors:** • Therapy is approvable for a total of 24 weeks in patients that are HCV genotypes 2 or 3 who have achieved a virologic response (either undetectable HCV RNA [<50 IU/mL] or at least a 2-log drop in HCV
	Peg-Intron® **Peg-Intron Redipen®**	*Pegasys®* *Proclick/syringe/kit/vial*	

Preferred Agents	Non-Preferred Agents	SA Criteria
		RNA titer from baseline) at 12 weeks of treatment. • Therapy is approvable for total of 48 weeks in HCV genotype 1 or 4 patients who have achieved a virologic response (either undetectable HCV RNA [<50 IU/mL] or at least a 2-log drop in HCV RNA titer from baseline) at 12 weeks of treatment. • If patient fails to achieve a virologic response by 12 weeks, further treatment is not indicated.
Protease Inhibitor		

***Incivek®**
****Victrelis®**
	*****Olysio™**	**Clinical Criteria for Protease Inhibitors**
		• ***Incivek® (Triple Therapy)**
		  • Confirm diagnosis of HCV with genotype 1, AND concurrent therapy with ribavirin and peginterferon, AND no previous protease inhibitor treatment for Hep C.
		  • At initial prescription fill, if above criteria are met – approve for 12 weeks. Lab work needs to be done at 4 weeks.
		  • Course of telaprevir should *not* be repeated.
		• ****Victrelis® (Triple Therapy)**
		  • Confirm diagnosis of HCV with genotype 1, AND no previous protease inhibitor treatment for Hep C, AND completed ribavirin and peginterferon for at least 4 weeks, AND concurrent therapy with ribavirin and peginterferon
		  • Evaluate for the following conditions for longer duration of approval:
		  ○ Cirrhosis – Approve for 44 weeks
		  ○ Previous treatment with peginterferon and ribavirin with documented lack of achievement of > 2 log reduction at week 12 in previous treatment – Approve for 44 weeks.
		  ○ If none of above in a or b, then evaluate below to determine duration of therapy.
		  • At initial prescription fill, confirmed diagnosis of HCV with genotype 1 and completed 4 weeks of peginterferon and ribavirin with continuing therapy – approve for 24 weeks.
		  • After 24 weeks – require labs drawn at weeks 8 and 24. Depending on the result – determine the duration of approval:
		  ○ Treatment naïve patients:
		  ▪ If week 8 and 24 are both undetectable – triple therapy is

Preferred Agents	Non-Preferred Agents	SA Criteria
		completed. No further Victrelis® therapy. ▪ If week 8 results are detectable and week 24 results are undetectable – then approve Victrelis® for 8 more weeks. ▪ If week 24 results are detectable, discontinue all 3 therapies (Victrelis® and peginterferon/ribavirin). o Previously treated or relapsed patients: ▪ If week 8 and 24 are both undetectable – approve for 8 more weeks for Victrelis® and peginterferon/ribavirin (then discontinue all 3) ▪ If week 8 results are detectable and week 24 results are undetectable – then approve Victrelis for 8 more weeks. ▪ If week 24 results are detectable, discontinue all 3 therapies (Victrelis and peginterferon/ribavirin). • For ALL patients –If at week 12, the HCV-RNA level is > 100 IU/mL, do not approve Victrelis®. • For ALL patients - If at week 24 HCV-RNA results are detectable, discontinue all 3 therapies (Victrelis® and peginterferon/ribavirin). • Lab work needs to be done at 8, 12, and 24 weeks. *****Olysio™ (Triple Therapy) Initial Approval** • Length of authorization: 8 weeks for all three agents • Prescribed by or in consultation with a gastroenterologist, hepatologist, or infectious disease physician. • Diagnosis of hepatitis C virus (HCV) with genotype 1 showing fibrosis corresponding to a Metavir score of F3 or greater; **AND** • Patient CANNOT have failed therapy with an oral protease inhibitor indicated for HCV (e.g., Incivek®, Victrelis®, or Olysio®); **AND** • Must have concurrent (or planning to start) therapy with ribavirin and peginterferon when starting simeprevir; **AND** • Must be an adult patient age 18 and over; **AND** • Patient has NOT had liver transplant; **AND** • Patient is NOT infected with HCV genotype 1a containing the Q80K polymorphism; **AND** • Patient is NOT co-infected with HCV/HIV; AND • Patient is NOT receiving concomitant therapy with sofosbuvir (Sovaldi™).

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
		• Patient must be evaluated for current history of substance abuse and alcohol with validated screening instruments. *****Olysio™ (Triple Therapy) Renewal Criteria** • Confirmation the patient has been compliant with drug therapy regimen (per pharmacy paid claims history) • The prescriber can submit clinical rational for treatment continuation, for positive tests that are false positives and not thought to be due to a relapse in alcohol or substance abuse. o Test results will need to be submitted along with other lab work for renewals • A CLIA-certified laboratory should be used for ongoing lab monitoring. • After 8 weeks of therapy, approve simeprevir, peginterferon alfa and ribavirin for an additional 4 weeks of therapy if HCV-RNA is < 25 IU/mL at treatment week 4 (TW4). • After 8 weeks of therapy, discontinue simeprevir, peginterferon alfa, and ribavirin if HCV-RNA is ≥25 IU/mL at TW4.

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Nucleotide Analog NS5B Polymerase Inhibitor		**Clinical Criteria for Nucleotide Analog NS5B Polyerase Inhibitor**
	Sovaldi®	➢ **Sovaldi® Initial Approval** • Length **of authorization:** 8 weeks • Must be prescribed by or in consultation with a gastroenterologist, hepatologist, or infectious disease physician. • Genotypes 1, 2, 4 (**triple therapy**) – Treatment Week 8 (TW8) pending HCV RNA at TW4, then 4 additional weeks of therapy for a total duration of 12 weeks. • Genotypes 1 and 3 (**dual therapy**) – (TW8) Pending HCV RNA at TW4, then 8 additional weeks of therapy and (TW16) HCV RNA at TW12, then 8 additional weeks of therapy for a total duration of 24 weeks. • Up to 48 weeks in hepatocellular carcinoma if awaiting liver transplant Genotypes 1, 2, 3, 4 pre-transplant. • Adult patients age ≥18 years old. • Patient must be treatment naïve to sofosbuvir. • Patient is not receiving concomitant therapy with a hepatitis protease inhibitor (e.g., telaprevir [Incivek®], boceprevir [Victrelis®], simeprevir [Olysio®]). • Showing fibrosis corresponding to a Metavir score of F3 or greater. • Diagnostic/Disease Severity Evidence (must be attached to request) • Patient must be evaluated for current history of substance abuse and alcohol with validated screening instruments ➢ **Sovaldi® Renewal Criteria** • Confirmation the patient has been compliant with drug therapy regimen (per pharmacy paid claims history). • The prescriber can submit clinical rational for treatment continuation, for positive tests that are false positives and not thought to be due to a relapse in alcohol or substance abuse. • Test results will need to be submitted along with other lab work for renewals • A CLIA-certified laboratory should be used for ongoing lab monitoring.
Herpes Oral		

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	acyclovir tab/susp **famciclovir** **valacyclovir**	*Famvir®* *Valtrex®* *Zovirax® tab/susp*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit**
	Herpes Topical		
	Abreva OTC® **Zovirax® ointment**	*acyclovir oint* *Denavir®* *Xerese® cr* *Zovirax® cr*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit**
	Influenza		
	amantadine tab/syrup **Relenza Disk®** **rimantadine** **Tamiflu® cap/susp**	*amantadine cap* *Flumadine® syrup/tab*	**LENGTH OF AUTHORIZATIONS:** Date of service only **Routine PDL edit**
Blood Modifiers			

	Berinert® (C1-inhibitor)
	Cinryze™ (C1-inhibitor)
	Kalbitor® (kallikrein inhibitor)
		Firazyr® (icatibant)	**LENGTH OF AUTHORIZATIONS:** Date of service (plus one additional supply for emergency use)
			Routine PDL edit plus
			Clinical Criteria for Blood Modifiers
			• Must be prescribed and under direct care by a board-certified allergist, immunologist or hematologist
			• For prophylaxis must have
			  ○ HAE attacks occur at least once monthly
			  ○ Disabled at least 5 days per month
			  ○ History of attacks with airway compromise / hospitalization
			  ○ History of Prior prophylaxis with danazol:
			  ▪ danazol contraindicated (pediatric, hepatic or renal impairment, pregnancy, breast-feeding, abnormal genital bleeding)
			  ▪ Developed danazol toxicity
			  ▪ Diminished danazol efficacy
			FDA Indications and Quantity Limits
			• Berinert® Acute abdominal, facial or laryngeal HAE attacks (20 U per kg) 500 units/ vial- 4 vials per attack (plus 4 for emergency)
			• Cinryze™ Prevention of HAE attacks. Cinryze; 1,000 U - IV twice/week (500 units/vial) 20 vials per 34 days

Preferred Agents	Non-Preferred Agents	SA Criteria
		• Kalbitor® Acute HAE attacks in patients 16 years of age and older. (3-10 mL per dose Health care person to administer) 1 dose (plus one for emergency) • Firazyr® Acute attacks of (HAE) in adults 18 years of age and older; 30mg/dose (plus one for emergency)
Bone Resorption Suppression and Related Agents		
Bisphosphonates		
alendronate **Fosamax® soln**	*Actonel®* *Actonel® with CA* *alendronate soln* *Atelvia DR®* *Boniva®* *Binosto™* **Didronel®* *etidronate* *Fosamax®* *Fosamax® plus D* *ibandronate*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit** *Indicated only for treatment of Paget's disease of bone OR prevention and treatment of heterotopic ossification following total hip replacement or spinal cord injury.
Calcitonins		
Fortical®	*calcitonin-salmon nasal* *Miacalcin®*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit**
Others		
Evista®	*Forteo®* *raloxifene*	**LENGTH OF AUTHORIZATIONS**: Initial approval will be for 1 year with ONE renewal if demonstrated compliance. Maximum duration of therapy is 24 months during a patient's lifetime. **Routine PDL edit plus** **Clinical Critieria for Forteo® (teriparatide)** • Treatment of osteoporosis in postmenopausal women who are at high risk for fracture. • Increase of bone mass in men with primary or hypogonadal osteoporosis who are at high risk for fractures. • Treatment of men and women with osteoporosis associated with sustained systemic glucocorticoid therapy at high risk for fracture.

Preferred Agents	Non-Preferred Agents	SA Criteria

		• Bone mineral density of -3 or worse OR
		• Postmenopausal women with history of non-traumatic fracture(s) OR
		• Postmenopausal women with two or more of the following clinical risk factors:
		  ○ Family history of non-traumatic fracture(s)
		  ○ Patient history of non-traumatic fracture(s)
		  ○ DXA BMD T-score ≤-2.5 at any site
		  ○ Glucocorticoid use* (≥6 months of use at 7.5 dose of prednisolone equivalent)
		  ○ Rheumatoid Arthritis
		  ○ Postmenopausal women with BMD T-score ≤-2.5 at any site with any of the following clinical risk factors:
		  ▪ More than 2 units of alcohol per day
		  ▪ Current smoker
		  ▪ Men w/primary or hypogonadal osteoporosis
		  ▪ Osteoporosis associated w/sustained systemic glucocorticoid therapy

Cardiac

ACE Inhibitors, Angiotensin Receptors Blockers, Beta-Blockers

ACE Inhibitors	
benazepril **captopril** **enalapril** **lisinopril** **ramipril**	*Accupril®* *Aceon®* *Altace®cap/tab* *Epaned™ soln* *fosinopril* *Lotensin®* *Mavik®* *moexipril* *Monopril®* *perindopril* *Prinivil®* *quinapril* *ramipril* *trandolapril* *Univasc®*

LENGTH OF AUTHORIZATION: 1 year

Routine PDL edit

Preferred Agents	Non-Preferred Agents	SA Criteria
	Vasotec® *Zestril*®	
ACE Inhibitors + Calcium Channel Blocker Combinations		
amlodipine/benazepril	*Lotrel*® *Tarka*® *trandolapril/verapamil hydrochloride ER*	
ACE Inhibitors + Diuretic Combinations		
benazepril/HCTZ **captopril/HCTZ** **lisinopril/HCTZ**	*Accuretic*® *enalapril/HCTZ* *fosinopril/HCTZ* *Lotensin HCT*® *moexipril/HCTZ* *Prinzide*® *quinapril/HCTZ* *Uniretic*® *Univasc*® *Vaseretic*® *Zestoretic*®	
Angiotensin Receptor Blockers		
***Diovan**® **losartan**	*Atacand*® *Avapro*® *Benicar*® *candesartan* *Cozaar*® *Edarbi*® *eprosartan mesylate* *irbesartan* *Micardis*® *telmisartan/HCTZ* *Teveten*®	***Step edit requires a trial and failure of losartan**

Preferred Agents	Non-Preferred Agents	SA Criteria
Angiotensin Receptor Blockers + Calcium Channel Blocker Combinations		
	Azor® *Exforge®* *Exforge® HCT* *Tribenzor®*	
Angiotensin Receptor Blockers + Diuretic Combinations		
losartan/HCTZ ****valsartan/HCTZ**	*Atacand HCT®* *Avalide®* *Benicar HCT®* *candesartan/HCTZ* *Diovan HCT®* *Edarbyclor®* *Hyzaar®* *irbesartan/HCTZ* *Micardis HCT®* *Teveten HCT®*	****Step edit requires a trial and failure of losartan/HCTZ**
Beta Blockers		
atenolol **carvedilol** **labetalol** **metoprolol tartrate** **nadolol** **propranolol tab/soln** **Sorine®** **sotalol AF** **sotalol HCL**	*acebutaolol* *Betapace® IR & AF®* *betaxolol* *bisoprolol* *Bystolic®* *Coreg® IR & CR®* *Corgard®* *Inderal® XL* *Innopran® XL* *Kerlone®* *Levatol®* *Lopressor®* *metoprolol succinate* *pindolol* *propranolol LA* *Sectral®* *Tenormin®* *timolol maleate* *Toprol XL®*	

Preferred Agents	Non-Preferred Agents	SA Criteria
	Trandate® *Zebeta*®	
Beta Blockers + Diuretic Combinations		
atenolol/chlorthalidone **bisoprolol/HCTZ** **nadolol/bendroflume - thiazide** **propranolol/HCTZ**	*Corzide*® *Dutoprol*® *Inderide*® *Lopressor HCT*® *metoprolol/HCTZ* *Tenoretic*® *Ziac*®	
Direct Renin Inhibitors (includes combination)		
	Amturnide™ *Tekamlo*® *Tekturna*® *Tekturna HCT*® *Twynsta*® *telmisartan/amlodipine* *Valturna*®	
Anticoagulants		
Low Molecular Weight Heparin includes FactorXA Inhibitor		**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit plus**
Fragmin® Syringe **Lovenox®**	*Arixtra*® *enoxaparin* *fondaparinux* *Fragmin®vial* *Innohep*®	
Oral Anticoagulants		***Clinical Criteria for Anticoagulant, Oral** ➢ ***Pradaxa** • May be approved for the following diagnosis ○ To reduce the risk of stroke and systemic embolism in patients with non-valvular atrial fibrillation OR ○ For the treatment of deep venous thrombosis (DVT) and pulmonary embolism (PE) in patients who have been treated with a parenteral anticoagulant for 5-10 days OR ○ To reduce the risk of recurrence of DVT and PE in patients who have been previously treated
warfarin ***Pradaxa®** ****Xarelto®**	*Coumadin®* ****Eliquis*™	

Preferred Agents	Non-Preferred Agents	SA Criteria
		➢ **** Xarelto® (rivaroxaban)** • May be approved for the following diagnosis o Nonvalvular atrial fibrillation o Treatment of deep vein thrombosis (DVT) or o Pulmonary embolism (PE), or o For the reduction in the risk of recurrence of DVT and of PE for the prophylaxis of DVT, in patients undergoingknee or hip replacement surgery ➢ ***** Eliquis™** • May be approved for the following diagnosis: o Reduction in risk of stroke and systemic embolism in nonvalvular atrial fibrillation o Prophylaxis of DVT following hip or knee replacement surgery
Calcium Channel Blockers: Dihydropyridine CCB & Non-Dihydropyride CCB		
Dihydropyridine Calcium Channel Blockers		**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit**
Afeditab CR® **amlodipine** **Nifediac CC®** **Nifedical XL®** **nifedipine** **nifedipine ER** **nifedipine SA**	*Adalat®* *Adalat CC®* *Cardene®* *Cardene SR®* *Dynacirc® IR & CR®* *felodipine ER* *isradipine* *nisoldipine* *nicardipine* *Norvasc®* *Procardia®* *Procardia XL®* *Plendil®* *Sular®*	
Non-Dihydropyridine Calcium Channel Blockers		
Cartia XT® **Diltia XT®** **diltiazem IR, ER q 12 hr &24 hr**	*Calan® IR & SR* *Cardizem® IR,CD & LA* *Dilacor XR®* *diltiazem SR q 12hr*	

Preferred Agents	Non-Preferred Agents	SA Criteria
diltiazem XR **Taztia XT®** **verapamil tab IR & ER**	*Isoptin SR®* *Tiazac®* *verapamil ER cap* *Verelan®* *Verelan PM®*	
Lipotropics		
Bile Acid Sequestrants		**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit plus** Therapeutic failure to no less **than three-month trial of at least one medication not requiring SA**.
cholestyramine powder reg & light **colestipol tab** **Prevalite®** **Welchol ® tab**	*Colestid® granule/packet/tab* *colestipol HCl granules* *Questran® powder/powder Light* *Welchol® packet*	
Cholesterol Absorption Inhibitor (CAI)		
Zetia®		
Fibric Acid Derivatives		
gemfibrozil **Tricor®**	*Antara®* *fenofibrate (Tricor®)* *fenofibrate (Antara®)* *fenofibrate (Lipofen®)* *fenofibric acid* *Fenoglide®* *Lipofen®* *Lofibra®* *Lopid®* *Triglide®* *Trilipix™*	
HMG CoA Reductase Inhibitors and Combinations (High Potency Statins)		
atorvastatin **simvastatin**	*amlodipine/atorvastatin* *Caduet®* *Crestor®* *Lipitor®* *Livalo®* *Vytorin®* *Zocor®*	

Preferred Agents	Non-Preferred Agents	SA Criteria
HMG CoA Reductase Inhibitors and Combinations (Statins)		
lovastatin **pravastatin**	*Advicor*® *Altoprev*® *fluvastatin* *Lescol*® *Lescol XL*® *Mevacor*® *Pravachol*®	
Microsomal Triglyceride Transfer Protein Inhibitor		**Clinical Criteria for Lipotropics, Other**
	***Juxtapid* ™	➢ ****Juxtapid™** • Diagnosis of homozygous familial hypercholesterolemia (HoFH). • Prescriber must be certified with the Juxtapid™ REMS program. • Minimum age restriction of 18 years of age. • Patient has had treatment failure, maximum dosing with or contraindication to: statins, ezetimibe, niacin, fibric acid derivatives, omega-3 agents, and bile acid sequestrants.
Niacin Derivatives		
Niacor® **Niaspan**®	*niacin ER*	
Niacin Derivatives & HMG CoA Reductase Inhibitors Combination		
	**Simcor*®	
Omega 3 Fatty Acid Agent		➢ *****Lovaza**® • Step edit requires trial and failure of any other lipotropic. • A SA may also be approved without a documented medication trial if patient has documented high triglycerides of ≥ 500 mg/dL.
	***Lovaza*® *omega-3 acid ethyl esters*	
Oligonucleotide Inhibitor		******Kynamro™** • Diagnosis of homozygous familial hypercholesterolemia (HoFH). • Prescriber must be certified with the Kynamro™ REMS program. • Minimum age restriction of 18 years of age. • Patient has had treatment failure, maximum dosing with or contraindication to: statins, ezetimibe, niacin, fibric acid derivatives, omega-3 agents, and bile acid sequestrants
	*****Kynamro™*	

	Preferred Agents	Non-Preferred Agents	SA Criteria
	Platelet Inhibitors		
	clopidogrel **dipyridamole** **Effient®** **ticlopidine HCL**	*Aggrenox®* *Brilinta®* *Persantine®* *Plavix®*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit**
	Pulmonary Arterial Hypertension Agents		
	Inhaled Prostacyclin Analogues		**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit**
	Tyvaso® **Ventavis®**		
	Oral Endothelin Receptor Antagonist		
	Letairis® **Tracleer®**	*Opsumit®*	

	Phosphodiesterase 5 Inhibitors		***Clinical Criteria for PDE-5**
			• Diagnosis of pulmonary hypertension in patients >18 years is required.
			• The requested medication may be approved if the following is true:
			  ○ The prescriber is a pulmonary specialist or cardiologist and will be followed by the prescribing physician.
			• Must have a rationale for not taking the oral Revatio® to receive a SA for the injectable Revatio®.
			• PDE-5 contraindications where SA should not be approved:
			  ○ Concurrent use of nitrates (e.g., nitroglycerin)
			  ○ Hypersensitivity to product

	***sildenafil**	**Adcirca™* **Revatio® oral* **Revatio® injection*	
	Prostacyclin Vasodilator		
		Orenitram™	
	Soluble Guanylate Cyclase Stimulators		
		Adempas®	
Central Nervous System			
	Alzheimer's Agents		
	Cholinesterase Inhibitors		**LENGTH OF AUTHORIZATIONS**: Length of prescription (up to 3 months)
	donepezil tab **Exelon® (transderm)**	*Aricept® ODT, tab & 23 mg tab* *donepezil ODT & 23mg tab* *Exelon® cap & soln* *galantamine IR, ER tab & soln* *Razadyne® IR, ER* *rivastigmine cap*	**Routine PDL edit**

Preferred Agents	Non-Preferred Agents	SA Criteria
NMDA Receptor Antagonist		When Namenda® tablet is not available, Namenda® XR will be preferred.
Namenda® soln/tab	*Namenda® Dose Pack & XR Tab*	
Antimigraine Agents		
Relpax® **sumatriptan succinate tab/cartridge/nasal/vial/ pen** **rizatriptan tab & MLT**	*Alsuma®* *Amerge®* *Axert®* *Cambia®* *Frova®* *Imitrex® cartridge/ nasal/pen/tab/vial* *Maxalt®tab &MLT* *naratriptan* *Sumavel® Dosepro* *Treximet®* *Zomig® tab/nasal spray/ZMT*	**LENGTH OF AUTHORIZATIONS:** **1 year** **Routine PDL edit**
Non-Ergot Dopamine Receptor Agonist		
pramipexole **ropinirole HCl**	Mirapex® IR & ER Neupro® Requip® IR & XR ropinirole HCl ER	**LENGTH OF AUTHORIZATIONS:** **1 year** **Routine PDL edit**
Sedatives / Hypnotics		
chloral hydrate syrup **flurazepam** **temazepam 15 & 30 mg**	*Doral®* *estazolam* *Halcion®* *Restoril®* *temazepam 7.5 mg & 22.5 mg* *triazolam*	**LENGTH OF AUTHORIZATIONS**: Length of the prescription (up to 3 months) **Routine PDL edit plus**
Sedatives / Hypnotics (Non-Benzodiazepine)		**Clinical Criteria for *Hetlioz™** Length of Authorization: 6 months. **For Renewal -** must document therapeutic benefit and confirm compliance • For the treatment of Non-24-Hour Sleep-Wake Disorder (Non-24). • The patient is completely blind. • Patient must be age 18 years of age or older • Quantity limit = 1 tablet per day
Rozerem® **zolpidem**	*Ambien® IR & CR* *Edluar™* *eszopiclone* **Hetlioz™* *Intermezzo®* *Lunesta®* *Silenor®* *Somnote®*	

Preferred Agents	Non-Preferred Agents	SA Criteria
	Sonata® *Zaleplon®* *zolpidem CR* *Zolpimist ™ spray*	
Skeletal Muscle Relaxants		
baclofen **chlorzoxazone** **cyclobenzaprine HCL** **dantrolene sodium** **methocarbamol** **tizanidine tab**	*Amrix®* ***carisoprodol*** **carisoprodol/ASA* **carisoprodol/ASA/codeine* *cyclobenzaprine ER* *Dantrium®* *Fexmid®* *Flexeril®* *Lorzone®* *metaxalone* *Norflex®* *orphenadrine citrate* *orphenadrine/ASA/caffeine* *Parafon Forte® DSC* *Robaxin®* *Skelaxin®* **Soma®* *tizanidine cap* *Zanaflex®*	**LENGTH OF AUTHORIZATIONS:** • 1 year for chronic conditions • Duration of prescription (up to 3 months) for acute conditions • One month per every 6 months carisoprodol products **Routine PDL edit plus** ***Clinical Criteria for carisoprodol products** • The patient is at least 16 years of age. • Only approve for ACUTE, painful musculoskeletal conditions. Do not approve for chronic pain. • Quantity limit = 4 tablets per day • Limit approval to one month supply (120 tablets) • Additional authorization will not be granted for at least 6 months following the last day of the previous course of therapy.
Smoking Cessation		
bupropion SR **Chantix®** **Chantix® Tab DS PK** **nicotine gum/ lozenge/ patch**	*Nicoderm CQ® Patch* *Nicorette® Gum/Lozenges* *Nicotrol® Inhaler & NS* *Zyban®*	**LENGTH OF AUTHORIZATIONS:** 6 months **Routine PDL edit**
Stimulants/ADHD Medications		
Amphetamine Products		**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit plus** **Step Edit for*Adderall XR®** If a trial & failure of a preferred product occurs and the physician requests
***Adderall®XR** **amphetamine salts combo** **dextroamphetamine** **Vyvanse®**	*Adderall® IR* *amphetamine salts combo XR* *Desoxyn®* *Dexedrine®*	

<table>
<tr><th></th><th>Preferred Agents</th><th>Non-Preferred Agents</th><th>SA Criteria</th></tr>
<tr><td></td><td></td><td>dextroamphetamine SR & Sol
Dextrostat®
methamphetamine
Procentra® soln
Zenzedi™</td><td>Adderall XR® or amphetamine salts combo XR. The brand Adderall XR®- is preferred over the generic.

** <u>Clinical Criteria for all Stimulants/ADHD products</u>
Length of Authorization: 1 year
Each product listed below will require an SA for ages less than the FDA/PI indicated age.
<table><tr><th>Brand name</th><th>PI age less than</th></tr><tr><td>Extended-release once-daily products; e.g., Adderall XR, Metadate CD, Concerta® Ritalin LA® etc.</td><td>6 years</td></tr><tr><td>Focalin XR®</td><td>6 years</td></tr><tr><td>Intuniv®</td><td>4 years</td></tr><tr><td>Immediate release formulations: e.g.,methylphenidate</td><td>3 years</td></tr><tr><td>Kapvay® SR</td><td>6 years</td></tr><tr><td>Strattera®</td><td>6 years</td></tr></table></td></tr>
<tr><td></td><td>Methylphenidate Products</td><td></td><td></td></tr>
<tr><td></td><td>Focalin XR®
All methylphenidate generic IR tablets
methylphenidate SR</td><td>Concerta®
Daytrana®
dexmethylphenidate IR & XR
Focalin®
Metadate CD®
Metadate ER®
Methylin ER®
Methylin chew®
Methylin® soln
methylphenidate soln
methylphenidate LA
Ritalin®
Ritalin LA®
Ritalin SR®
****Quillivant ™ XR 25 mg/5 mL susp</td><td>***<u>Quillivant™ XR</u>
• Methylphenidate SR and all methylphenidate IR tablets generic are covered without SA; clinical reason as to why the extended release suspension is required.</td></tr>
<tr><td></td><td>Miscellaneous Products</td><td></td><td></td></tr>
<tr><td></td><td>Strattera®</td><td>clonidine ER (Kapvay®)
Intuniv®
Kapvay® SR 12H
****modafinil
****Nuvigil ™</td><td>****<u>Nuvigil™/Provigil®/modafinil:</u>:
Length of Authorizations: 1 year for sleep apnea and narcolepsy; 6 months for shift work sleep disorder.

• Approvable diagnosis include:
○ Sleep Apnea: Requires documentation/confirmation via sleep study.</td></tr>
</table>

Preferred Agents	Non-Preferred Agents	SA Criteria
	****Provigil®	○ Requires documentation that C-PAP has been maximized. ○ **Narcolepsy:** Documentation of diagnosis via sleep study. ○ **Shift Work Sleep disorder: ONLY APPROVABLE FOR 6 MONTHS**, work schedule must be verified and documented. Shift work is defined as working the all night shift. • Minimum age of 16 years for Provigil® • Minimum age of 17 years for Nuvigil™

Dermatologic

Dermatologic Agents

Combination Benzoyl Peroxide & Clindamycin for Acne

LENGTH OF AUTHORIZATIONS: 1 year

Routine PDL edit plus

Failure to respond to a therapeutic trial of at least two weeks of one preferred medication.

Clinical Criteria for Dermatologic Acne Agents

- Prescriptions for patients over the age of 18 years will require a SA to determine diagnosis for treatment.
- Products are intended for acne **only; a SA for a cosmetic indication cannot be approved**

benzoyl peroxide wash/cream/gel/lotion (OTC)\ clindamycin phosphate gel/lotion/soln **Panoxyl-4 Acne Creamy Wash OTC**	*Acanya™ w/pump* *Acne Clearing System® OTC* *Azelex®* *Benzaclin®* *Benzefoam™ regualr &Ultra™* *Benzepro* *benzoyl peroxide wash/ cream/gel/lotion/foam/towelette (RX)* *benzoyl peroxide 6% cleanser OTC* *BPO Kit* *Cleocin T®* *Clindacin™ Pac Kit* *Clindagel®* *clindamycin / benzoyl peroxide (Benzaclin) & (Duac)generics* *clindamycin phosphate foam/lotion/med.swab* *Delos Lotion™* *Duac® gel* *Evoclin™* *Inova™* *Lavoclen ™ Cleanser & Kit* *Pacnex ®HP & LP* *Se BPO 7-5.5% Wash Kit*

Preferred Agents	Non-Preferred Agents	SA Criteria
	Se BPO Cleanser	
Topical Agents for Psoriasis		
Dovonex® **calcipotriene solu**	*anthralin* *calcipotriene cr/oint* *Calcitrene®* *calcitriol* *Dovonex® Scalp* *Micanol®* *Sorilux™* *Taclonex®* *Taclonex® Scalp* *Vectical*	
Topical Retinoids/Combinations for Acne		**Clinical Criteria for Fabior™ Foam** • Patient between the ages of 12 and 18 years of age • All prescriptions for patients over the age of 18 years will require a SA to determine diagnosis for treatment. • Products are intended for acne only; a SA for a cosmetic indication cannot be approved.
Differin® **tretinoin**	*adapalene 0.1% cream /gel* *Altinac®* *Atralin* *Avita® cream / gel* *Epiduo®* *Fabior ™ Foam* *Retin®A cream/gel* *Retin®-A Micro gel &Pump* *Tazorac®* *Tretin®-X* *tretinoin microsphere gel & gel pump* *Ziana®*	
Endocrine and Metabolic Agents		
Androgenic Agents (Testosterone – Topical)		
Androgel®	*Androderm®* *Axiron® soln* *Fortesta®* *Testim®*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit plus** Failure to respond to a therapeutic trial of at least one week of one preferred medication

	Preferred Agents	Non-Preferred Agents	SA Criteria
	Antihyperuricemics		

	allopurinol
	Probenecid®
	probenecid & colchicine
		**Colcrys®*
		Uloric®
		Zyloprim®
			LENGTH OF AUTHORIZATIONS: 1 year
			Routine PDL edit
			***Clinical Criteria for Colcrys™**
			• Diagnosis of Familial Mediterranean Fever; OR
			• For Acute Gout Flare:
			  ○ Trial and failure of one of the following:
			  ▪ NSAID or
			  ▪ Corticosteroid

	Contraceptives		
	Etonogestrel/Ethinyl Estradiol Vaginal Ring		**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit**
	NuvaRing®		
	Norelgestromin/Ethinyl Estradiol Transdermal		
	Ortho Evra®		
	Oral Contraceptives		
	Apri® **Cryselle™** **Enpresse®** **Femcon Fe®** **Junel Fe®** **Loestrin®** **Loestrin Fe®** **Microgestin®** **Microgestin Fe®** **Mircette®** **Micronor®** **Norinyl 1+50®** **Nor-Q-D®** **Nortrel ®** **Ortho-Novum®** **Ortho Tri-Cyclen®** **Ortho Tri-Cyclen Lo®** **Ovcon®-50** **Sprintec®**	*All other oral contraceptives*	

	Preferred Agents	Non-Preferred Agents	SA Criteria
	Tri-Sprintec® **Trivora-28®** **Yasmin ®28** **Yaz®** **Zovia® 1-35E & 1-50E**		
	Diabetes Hypoglycemics: Injectable Amylin Analogs		
		**SymLin®* **SymLin® Pens*	**LENGTH OF AUTHORIZATIONS**: 1 year ***Clinical Criteria for Injectable Amylin Analogs** • Patient must have a history of at least a 90 day trial of insulin. • SymLin® is only indicated as adjunct therapy with insulin. • Patient meeting ALL of the following criteria may be approved: o Diagnosis of Type 1 or 2 diabetes o On insulin therapy o Failure to achieve adequate glycemic control (HbA1c ≤ 6.5%)
	Diabetes Hypoglycemics: Injectable Incretin Mimetics		
	Byetta®	*Bydureon™* *Victoza®*	**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edit**
	Diabetes Hypoglycemics: Injectable Insulins		
	Insulin Mix		**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edit**
	Humalog® Mix 50/50 vial **Humalog® Mix 75/25 vial** **Humulin® 70/30 vial** **Novolog® Mix 70/30 pen/ vial**	*Humalog® Mix 50/50 Kwikpen* *Humalog® Mix 75/25 Kwikpen* *Humulin® 70/30 pen (OTC)* *Novolin® 70/30 vial (OTC)*	
	Insulin N		
	Humulin® N vial (OTC)	*Humulin® N pen* *Novolin® N vial (OTC)*	
	Insulin R		
	Humulin® R vial	*Novolin® R vial (OTC)*	

Preferred Agents	Non-Preferred Agents	SA Criteria
Long-Acting Insulins		
Lantus® vial **Levemir® pen/vial**	*Lantus Solostar®/cartridge*	
Rapid-Acting Insulins		
Humulin 500 U/M vial **Humalog® vial** **Novolog® cartridge/ Flexpen/vial**	*Apidra® cartridge/Solostar/vial* *Humalog® Cartridge* *Humalog Kwikpen®*	
Diabetes Oral Hypoglycemics		
Oral Hypoglycemics Alpha-Glucosidase Inhibitors		**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit**
acarbose **Glyset®**	*Precose®*	
Oral Hypoglycemics Biguanides		
metformin **metformin ER** (generic for Glucophage® XR)	*Fortamet®* *Glucophage® IR & XR* *Glutmetza®* *Riomet® susp* *metformin ER (generic for (Fortamet®)*	
Oral Hypoglycemics Biguanide Combination Products		
glyburide/metformin	*glipizide/metformin* *Glucovance®* *Metaglip®*	
Oral Hypoglycemics DPP-IV Inhibitors and Combination		
Janumet® **Janumet XR®** **Januvia®** **Jentadueto™** **Tradjenta™**	*Juvisync™* *Kazano™* *Kombiglyze XR™* *Nesina™* *Onglyza™* *Oseni™*	
Oral Hypoglycemics Meglitinides		
Starlix®	*nateglinide* *Prandin®* *PrandiMet™*	

Preferred Agents	Non-Preferred Agents	SA Criteria
Oral Hypoglycemics Second Generation Sulfonylureas		
glimepiride **glipizide** **glipizide ER** **glyburide** **glyburide micronized**	*Amaryl®* *Diabeta®* *Glucotrol®* *Glucotrol XL®* *Glynase®*	
Oral Hypoglycemics Sodium Glucose Co-Transporter 2 Inhibitor (SGLT2)		**Clinical Criteria for Oral Hypoglycemics: Sodium Glucose Co-Transporter 2 Inhibitor (SGLT2)** **Initial criteria for approval for6 months. Renewals for 1 year.** • Approve for Type 2 diabetics who have been compliant with and have not achieved adequate glycemic control with metformin, OR are intolerant to metformin. • Minimum age restriction of 18 years of age • Quantity limit = 1 tablet per day
	Farxiga™ *Invokana™*	
Oral Hypoglycemics Thiazolidinediones		
pioglitazone	*Avandia®* *Actoplus Met® IR & XR* *Actos®* *Avandaryl®* *Avandamet®* *Duetact®* *pioglitazone/metformin*	
Erythropoiesis Stimulating Proteins: Epogen®, Procrit® (Erythropoietin) & Aranesp® (Darbepoetin)		
Procrit®	*Aranesp®* *Epogen®*	**LENGTH OF AUTHORIZATIONS**: for duration of the prescription up to 6 months **Routine PDL edit** *Omontys® is not PDL eligible, may be covered under medical benefit*
Growth Hormone		
Genotropin® **Nutropin AQ® NuSpin™**	*Humatrope® cartridge/vial* *Norditropin cartridge®* *Norditropin FlexPro®&* *Nordiflex®* *Nutropin®*	**LENGTH OF AUTHORIZATIONS**: 1 year **Clinical Criteria for PEDIATRIC Patients (18 years of age and under)** • Prescriber is an endocrinologist, nephrologist, infectious disease specialist or HIV specialist or one has been consulted on this case,

Preferred Agents		Non-Preferred Agents	SA Criteria

		Nutropin AQ® cartridge/vial
		Omnitrope®
		Saizen® cartridge/vial
		**Serostim®*
		Tev-Tropin®
		***Zorbtive®*
			• The patient has open epiphysis and one of the following diagnoses
			  ○ Turner Syndrome
			  ○ Prader-Willi Syndrome
			  ○ Renal insufficiency
			  ○ Small for gestational age (SGA) - including Russell-Silver variant and patient is < 2 years old
			  ○ Idiopathic Short Stature (for request for renewal only (a) information is required to be approved)
			  ○ Growth hormone deficiency (physician should provide the required information below)
			  ○ Newborn with hypoglycemia and a diagnosis of hypopituitarism or panhypopituitarism.
			• Height is more than 2 SD (standard deviations) below average for the population mean height for age and sex, and a height velocity measured over one year to be 1 SD below the mean for chronological age, or for children over two years of age, a decrease in height SD of more than 0.5 over one year; AND
			• Growth hormone response of less than 10ng/mL to at least two provocative stimuli of growth hormone release: insulin, levodopa, L-Arginine, clonidine, or glucagon
			
			Clinical Critieria for Renewal (pediatrics):
			• For renewal, a response must be documented. Patient must demonstrate improved/normalized growth velocity. (Growth velocity has increased by at least 2 cm in the first year and is greater than 2.5 cm per year), AND
			• Patient height is more than 1 standard deviation (2") below mid-parental height (unless parental height is diminished due to medical or nutritional reasons).
			
			Clinical Criteria for ADULTS (> 18 years of age)
			• Prescriber is an endocrinologist
			• Diagnosis of growth hormone deficiency confirmed by growth hormone stimulation tests and rule-out of other hormonal deficiency, as follows: growth hormone response of fewer than five nanograms per mL to at least two provocative stimuli of growth hormone release: insulin, levodopa, L-Arginine, clonidine or glucagon when measured by polyclonal antibody (RIA) or fewer than 2.5 nanograms per mL when

Preferred Agents	Non-Preferred Agents	SA Criteria
		measured by monoclonal antibody (IRMA); • Cause of growth hormone deficiency is Adult Onset Growth Hormone Deficiency (AO-GHD), alone or with multiple hormone deficiencies, such as hypopituitarism, as a result of hypothalamic or pituitary disease, radiation therapy, surgery or trauma • Other hormonal deficiencies (thyroid, cortisol or sex steroids) have been ruled out or stimulation testing would not produce a clinical response such as in a diagnosis of panhypopituitarism. ***Serostim®** • Diagnosis of AIDS wasting or cachexia • Has a documented failure, intolerance, or contraindication to appetite stimulants and/or other anabolic agents (both Megace® & Marinol®) • ***Length of Authorization**: 3 months initial; then 1 year. Renewal is contingent upon improvement in lean body mass or weight measurements. ****Zorbtive®** - Diagnosis of short bowel syndrome
Progestational Agents		
medroxyprogesterone acetate (tablet only) **norethindrone acetate** **progesterone injection** **Prometrium®**	*Aygestin®* *progesterone cap* *Provera®*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit plus** Failure to respond to a therapeutic trial of at least one week of one preferred product.
Progestins Used For Cachexia		
megestrol acetate	*Megace®* *Megace® ES*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit**
Vaginal/Oral Estrogens		
Premarin® Vaginal cr **Vagifem® Vaginal tab**	*Estrace ®Vaginal cr* *Estring® Vaginal ring* *Femring® Vaginal ring* *Osphena® tab*	**LENGTH OF AUTHORIZATIONS**: 6 months **Routine PDL edit**

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Gastrointestinal		
Antiemetic/Antivertigo Agents (potential new class never reviewed)		
Cannabinoids (delta-9THC derivatives)		**LENGTH OF AUTHORIZATIONS:** 6 months **Routine PDL edit plus** **Clinical Criteria for Cannabinoids** ➢ ***Cesamet®** • Diagnosis of severe, chemotherapy induced nausea and vomiting • Patient has tried and failed, has a contraindication to, an intolerance, or a medical reason not to try the combination of Emend® plus a 5HT3 receptor antagonist plus a corticosteroid. • Patient has tried and failed megestrol acetate oral suspension OR has a contraindication, intolerance, drug-drug interaction, or medical reason megestrol acetate cannot be used. ➢ ****Dronabinol** • Diagnosis of severe, chemotherapy induced nausea and vomiting • Patient has tried and failed, has a contraindication to, an intolerance, or a medical reason not to try the combination of Emend® plus a 5HT3 receptor antagonist plus a corticosteroid • Diagnois of AIDS-relating wasting Patient has tried and failed megestrol acetate oral suspension OR has a contraindication, intolerance, drug-drug interaction, or medical reason megestrol acetate cannot be used.
Marinol ®	*Cesamet® **dronabinol	
5HT3 Receptor Blockers		**LENGTH OF AUTHORIZATIONS: 3 months, unless otherwise noted** **Routine PDL edit plus** *** Clinical Criteria for 5HT3 Receptor Blockers:** • Nausea or vomiting related to radiation therapy, moderate to highly emetogenic chemotherapy, or post-operative nausea and vomiting. • Patient has tried and failed therapeutic doses of, or has adverse effects or contraindications to, 2 different conventional antiemetics (e.g.,
ondansetron ODT/tab	**Anzemet®* **granisetron* **Granisol ® soln/tab* **Kytril®* *ondansetron soln* **Sancuso® ® patch* *Zofran®*ODT/soln/tab **Zuplenz® film*	

Preferred Agents	Non-Preferred Agents	SA Criteria
		promethazine, prochlorperazine, meclizine, metoclopramide, dexamethasone, etc.)
NK-1 Receptor Antagoni		**LENGTH OF AUTHORIZATIONS:** Length of chemotherapy regimen or a maximum of 6 months **Routine PDL edit plus** **Clinical Criteria for NK-1 Receptor Antagonist** ➢ ****Emend® (aprepitant)** • Emend® does NOT require treatment failure with preferred drugs when used for moderately or highly emetogenic chemotherapy. Quantity limits: One Emend® BiPack (2-80mg tablets) per chemotherapy treatment or, One Emend® TriPack (1-125mg tablet and 2-80mg tablets) per chemotherapy treatment.
	***Emend®* Bi Pak ***Emend® Tri-fold pack*	
Other		**LENGTH OF AUTHORIZATIONS**: 1 year, unless other wise noted Routine PDL edit plus **Clinical Critieria for Antiemetics/Antivertigo,Other** ➢ *Diclegis® (doxylamine/pyridoxine) • Patient must be pregnant ➢ ****Promethazine** • Patient must be 2 years or older ➢ *****Transderm-Scop®** may be approved for 3 months if: • Tried and failed at least oneof the following: meclizine, promethazine, dimenhydrinate, diphenhydramine, or metoclopramide; OR • is unable to swallow or absorb oral medications • will be in an area/situation for an extended period of time where taking short acting agents would not be feasible
meclizine **metoclopramide** **ondansetron tab & ODT** **prochlorperazine** ****promethazine**	*Antivert®* *Compazine®supp* *Compro®* **Diclegis®* *Dramamine®* *dimenhydrinate* *hydroxyzine* *Metozolv® ODT* ***Phenergan®* *prochlorperazine supp* *Reglan®* *Tigan®* ****Transderm-Scop®* *trimethobenzamide* *Vistaril®*	
Bile Salts		
ursodiol 300 mg cap	*Actigal®*	**LENGTH OF AUTHORIZATIONS**: 1 year

Preferred Agents	Non-Preferred Agents	SA Criteria
	Chenodal® *ursodiol tab* *Urso®Urso® Forte tab*	**Routine PDL edit**
H. Pylori Treatment		
Helidac® **Pylera®** **Prevpac®**	*Omeclamox®-Pak* *lansoprazole/amoxicillin/clarithromycin*	**LENGTH OF AUTHORIZATIONS**: 14 days **Routine PDL edit**
Histamine-2 Receptor Antagonists (H-2 RA)		
famotidine (OTC & RX) **ranitidine tab/syrup (OTC & RX)**	*Axid® cap/soln (OTC/RX)* *cimetidine tab/syrup (OTC/RX)* *famotidine oral susp (OTC/RX)* *nizatidine cap/susp* *Pepcid ® susp/tab (OTC/RX)* *ranitidine cap (OTC/RX)* *Tagamet® (OTC/ RX)* *Zantac® syrup/ tab (OTC/RX)*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit**
Irritable Bowel Syndrome		
***Amitiza®**	***Linzess™* ****Lotronex®*	**LENGTH OF AUTHORIZATIONS**: 6 months Routine PDL edit plus **Clinical Criteria** ➢ ***Amitiza®** • Must be 18 or older and • have one of the following diagnoses 1. Idiopathic Constipation with treatment failure of at least ONE product from TWO of the following classes: o Osmotic Laxatives (examples: lactulose, polyethylene glycol (PEG), sorbitol) o Bulk Forming Laxatives (examples: Metamucil® (psyllium), Citrucel®, fiber) o Stimulant Laxatives (examples: bisacodyl, senna) 2. Constipation Predominant Irritable Bowel Syndrome (IBS-C) o Patient is female; AND

Preferred Agents	Non-Preferred Agents	SA Criteria
		○ Treatment failure on at least ONE product from TWO of the following classes: ○ Osmotic Laxatives (examples: lactulose, polyethylene glycol (PEG), sorbitol) ○ Bulk Forming Laxatives (examples: Metamucil® (psyllium), Citrucel®, fiber) ○ Stimulant Laxatives (examples: bisacodyl, senna) 3. Opioid Induced Constipation in chronic NON-cancer pain ○ Patient has tried and failed both PEG (i.e., Miralax®) AND lactulaose ** ➢ **<u>Linzess</u>® • Diagnosis of Idiopathic Chronic Constipation or Constipation-Predominant Irritable Bowel Syndrome (IBS) • Patient must be at least 6 years of age; AND • Treatment failure on at least ONE agent from TWO of • the following classes: ○ Osmotic Laxatives (examples: lactulose, polyethylene glycol (PEG), sorbitol) ○ Bulk Forming Laxatives (examples: Metamucil® (psyllium), Citrucel®, fiber) ○ Stimulant Laxatives (examples: bisacodyl, senna) ***<u>Lotronex</u>® • Diagnosis of severe, diarrhea predominant Irritable Bowel Syndrome • Patient is female and at least 18 years of age; AND • Prescriber is enrolled in the Promethus Prescribing Program for Lotronex®, AND • Patient has had chronic IBS symptoms for at least 6 months; AND • Patient has tried and failed at least three agents from the following ○ bulk producing agents (e.g., psyllium, fiber), ○ antispasmodic agents (e.g., dicyclomine, hyoscyamine), ○ antidiarrheal agents/opiates (e.g., loperamide, diphenoxaylate/atropine, codeine)
Proton Pump Inhibitors		
pantoprazole	*Aciphex® DR tab/sprinkle*	**<u>LENGTH OF AUTHORIZATIONS</u>**:

Preferred Agents	Non-Preferred Agents	SA Criteria
Prilosec® OTC	*Dexilant®* *esomeprazole strontium* *lansoprazole (SA not required for soln if age < 12yrs)* *Nexium®* *omeprazole (RX & OTC)* *omeprazole/sodium bicarbonate* *Prevacid® RX, OTC& Solutab* *rabeprazole DR tab* *Prilosec® Rx & Susp* *Protonix®* *Zegerid® cap, OTC & Susp packet*	12 weeks; unless patient meets an exception; then 1 year **Routine PDL edit plus** **Additional PDL edit criteria** The requested medication may be approved if both of the following are true: • If there has been a therapeutic failure of no less than a **three-month trial** of **at least two different** medication within the same class not requiring service authorization **Exceptions that allow for a 1 year SA for PPIs** (Exceptions apply to the duration of the SA only. PDL edit still prevails before a non-preferred may be approved) • Erosive Esophagitis • Active GI Bleed • Zollinger-Ellison Syndrome • Greater than 65 years of age • Under the care of a Gastroenterologist and has ruled out a nonsecretory condition
Ulcerative Colitis Oral and Rectal Preparations (5-ASA DERIVATIVES)		
Ulcerative Colitis – Oral		**LENGTH OF AUTHORIZATIONS: 1 year** **Routine PDL edit** *Giazo is limited to an 8 week supply
Asacol® **Apriso®** **balsalazide disodium** **Pentasa®** **sulfasalazine DR & IR**	*Asacol ®HD* *Azulfidine® IR &DR* *Colazal®* *Delzicol™* *Dipentum* **Giazo™* *Lialda ®* *Uceris™*	
Ulcerative Colitis – Rectal		
Canasa® rectal supp **mesalamine enema**	*Fiv-Asa®* *mesalamine kit* *Rowasa® enema/supp/kit* *SFRowasa®*	
Genitourinary		
Alpha-Blockers and Androgen Hormone Inhibitors For Benign Prostatic Hypertrophy (BPH)		
Alpha-Blockers for BPH		**LENGTH OF AUTHORIZATIONS: 1 year**
alfuzosin	*Flomax ®*	

	Preferred Agents	Non-Preferred Agents	SA Criteria
	tamsulosin HCL	*Rapaflo®* *Uroxatral®*	**Routine PDL edit plus** ***Step edit for Avodart® -** the generic finasteride must be tried and failed before approval ****Step edit for Cialis® -** must try and fail both Alpha Blockers and Androgen Hormone Inhibitors for BPH and the prescriber must attest that the patient is not on the state list of sex offenders. The patient must have had a consult or been evaluated by an Urologist.
	Androgen Hormone Inhibitors for BPH		
	***Avodart®** **finasteride**	*Jalyn®* *Proscar®*	
	Phosphodiesterase (PDE) 5 Inhibitor for BPH		
		***Cialis®*	
	Phosphate Binders		
	calcium acetate 667mg cap **Fosrenol®** **Renagel®**	*calcium acetate 667mg tab* *Eliphos®* *Phoslo®* *Phoslyra®* *Renvela® powder/tablet* *sevelamer carbonate* *Velphoro® chewable tablet*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit**
	Urinary Antispasmodics		
	oxybutynin tab/syrup **Oxytrol® transdermal** **Sanctura® XR** **Toviaz™** **VESIcare®**	*Detrol® & Detrol® LA* *Ditropan® & *Ditropan® XL* *Enablex®* *flavoxate* *Gelnique™ gel* *Myrbetriq™* **oxybutynin ER* *Sanctura®* *trospium IR & ER* *tolterodine IR & ER*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit** ***Oxybutynin ER, Ditropan XL®:** • Allow PDL exception for children age 6-18 with a diagnosis of neurogenic bladder.
Immunological Agents			
	Atopic Dermatitis: Topical		
	***Elidel®**	**Protopic®*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit plus**

Preferred Agents	Non-Preferred Agents	SA Criteria
		***Clinical Criteria for Atopic Dermatitis, Topical** ➢ **Elidel® and Protopic®** • Patient must have a FDA approved diagnosis: ○ Atopic dermatitis (a type of eczema): ○ Elidel®: mild to moderate for ages > 2 years. ○ Protopic® 0.03%: moderate to severe for ages > 2 years. ○ Protopic® 0.1%: moderate to severe for ages > 18 years. • Failure to topical corticosteroids (i.e., desonide, fluticasone propionate, hydrocortisone butyrate, etc.)
Multiple Sclerosis		
Avonex® **Avonex® Adm Pack** **Copaxone Kit®** **Extavia® Kit & Vial** **Rebif® SQ**	**Ampyra®* *Aubagio®* *Betaseron®* *Copaxone® 40 mg syringe®* *Gilenya®* *Rebif® Rebi dose Pen®* *Tecfidera™*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit plus** Gilenya® is to be used as monotherapy ONLY. ***Clinical Criteria for AMPYRA®** • The patient has a diagnosis of Multiple Sclerosis and a gait disorder. • Patient has no history of seizures • Patient's Creatinine Clearance [CrCL] ≥ 50 mL/min. • If after 8 week trial the prescriber states that the patient showed improvement or that the drug was effective (by improved Timed 25-foot Walk), the patient may receive authorization for Ampyra® for one year.
Self Administered Drugs for Rheumatoid Arthritis		
Enbrel® **Humira®**	*Actemra® SQ* *Cimzia®* *Cimzia® Syringe Kit* *Kineret®* *Otezla®* *Orencia®* *Simponi®* **Xeljanz™*	**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edit plus** **Clinical Criteria for *Xeljanz™** • For the treatment of moderately to severely active rheumatoid arthritis in patients who have had an inadequate response or intolerance to methotrexate. • The patient had a therapeutic trial and treatment failure with **ONE** of the following preferred drugs: Enbrel®, or Humira®, AND • Trial and failure of methotrexate therapy.

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Ophthalmic		
Antibiotics		
bacitracin/polymyxin b sulfate ointment **ciprofloxacin drops** **erythromycin** **gentamicin drops/oint** **Moxeza® drops** **neomycin/polymyxin/ gramicidin** **ofloxacin drops** **polymyxin/trimethoprim** **sulfacetamide soln** **tobramycin** **Vigamox® drops**	*AzaSite™ drop* *bacitracin* *Besivance® drops* *Bleph®- 10* *Ciloxan® drops/oint* *Garamycin ®drops/oint* *gatifloxacin 0.5% soln* *Ilotycin®* *levofloxacin drops* *Natacyn®* *neomycin/bacitracin/ polymyxin ointment* *Neosporin ®* *Ocuflox® drops* *Polytrim®* *sulfacetamide ointment* *Tobrex® drops/ointment* *Zymaxid® drops*	**LENGTH OF AUTHORIZATIONS**: for the date of service only; no refills **Routine PDL edit**
Antibiotic/Steroid Combinations		
neomycin/polymyxin/ dexamethasone oint/susp **Tobradex® oint/susp**	*Blephamide® & Blephamide® S.O.P.* *Maxitrol® Oint. & Susp* *neomycin/bacitracin/poly/ HC* *neomycin/polymyxin/HC* *Pred-G®oint/susp* *sulfacetamide/prednisolone* *Tobradex® ST* *Tobramycin/dexamethasone susp* *Zylet®*	**LENGTH OF AUTHORIZATION**: for the date of service only; no refills **Routine PDL edit**

Preferred Agents	Non-Preferred Agents	SA Criteria
Antihistamines/Mast Cell Stabilizers		
Antihistamines		**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit** *Ilevro™ is limited to 1 bottle plus 1 refill
Alaway OTC® **ketotifen fumerate** **Pataday® drops** **Zaditor® OTC drops**	*azelastine drops* *Bepreve®* *Elestat®drops* *Emadine® drop* *epinastine 0.05% eye drops* **Ilevro™ 0.3% drops* *Lastacaft® drops* *Optivar® drops* *Patanol® drops*	
Mast Cell Stabilizers		
cromolyn sodium	*Alocril® drops* *Alomide® drops* *Crolom® drops*	
Anti-inflammatory		
NSAIDS		**LENGTH OF AUTHORIZATIONS**: for the date of service only; no refills **Routine PDL edit** *Ilevro™ is limited to 1 bottle plus 1 refill
diclofenac sodium **flurbiprofen sodium** **ketorolac 0.4%& 0.5%** **Nevanac®**	*Acular® 0.5% & LS® 0.4%* *Acuvail®* *bromfenac 0.09%* *Ilevro™0.3% drops* *Ocufen®* *Prolensa™*	
Corticosteriods		
Durezol® **fluorometholone** **prednisolone acetate**	*Alrex™* *dexamethasone* *Flarex®* *FML®* *FML Forte®* *FML® S.O.P.* *Lotemax™ drops/gel/oint* *Maxidex®* *Omnipred®* *Pred Forte®* *Pred Mild®*	

Preferred Agents	Non-Preferred Agents	SA Criteria
	prednisolone sod phosphate *Vexol®*	
Glaucoma Agents		
Alpha 2 Adrenergic Agents		**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit**
Alphagan P® 0.1 & 0.15% **brimonidine 0.2%** **Iopidine® 0.5% & 1%**	*apraclonidine 0.5% drops* *brimonidine tartrate 0.15%*	
Beta Blockers		
Betimol® 0.25% &0.5% **Betoptic-S® 0.25%** **carteolol 1%** **levobunolol 0.25% & 0.5%** **metipranolol 0.3%** **timolol maleate**	*Betagan® 0.25% & 0.5%* *betaxolol 0.5%* *Combigan®* *Istalol® 0.5%* *optipranolol 0.3%* *Timoptic® drops 0.25% & 0.5%* *Timoptic® XE 0.25% & 0.5% sol-gel*	
Carbonic Anhydrase Inhibitors		
Azopt® 1% **dorzolamide** **dorzolamide/timolol** **Simbrinza™**	*Cosopt® 0.5%-2%* *Cosopt® PF* *Trusopt® 2%*	
Prostaglandin Analogs		
latanoprost **Travatan Z®**	*Lumigan® 0.03% & 0.01%* *Rescula®* *travoprost* 0.004% *Xalatan® 0.005%* *Zioptan™*	

<table>
<tr><th>Preferred Agents</th><th>Non-Preferred Agents</th><th>SA Criteria</th></tr>
<tr><td colspan="3">Respiratory</td></tr>
<tr><td colspan="3">Antihistamines: First and Second Generation</td></tr>
<tr><td colspan="2">First Generation Antihistamines</td><td rowspan="4"><u>LENGTH OF AUTHORIZATIONS</u>: 1 year

Routine PDL edit</td></tr>
<tr><td>Generic only class</td><td>All Brands require a SA</td></tr>
<tr><td colspan="2">Second Generation Antihistamines and Combinations</td></tr>
<tr><td>cetirizine liquid 1mg/1mL (RX/ OTC)
cetirizine tabs OTC
loratadine tab/syrup OTC</td><td>Allegra®
Allegra-D®
cetirizine chew tab (OTC)
cetirizine liquid 5mg/5mL (OTC)
cetirizine D tab (OTC)
Clarinex®
Clarinex-D®
Claritin®
Claritin® D
desloratadine ODT
fexofenadine
fexofenadine/PSE & 60/120 ER
levocetirizine
loratadine ODT
loratadine D 12 & 24 hr
Xyzal®
Zyrtec® tab/chew/syrup (OTC/RX)
Zyrtec-D® (OTC/ RX)</td></tr>
<tr><td colspan="3">Beta-Adrenergic Agents</td></tr>
<tr><td colspan="2">Long Acting Beta Adrenergic agents (LABA) Metered Dose Inhalers or Nebulizers</td><td rowspan="2"><u>LENGTH OF AUTHORIZATIONS</u>: 1 year

Routine PDL edit plus

<u>*Clinical Criteria for LABAs</u>
Length of Authorization 3 months for Clinical Criteria
Each product listed below will require a SA for ages less than the FDA/PI indicated age.
<table><tr><th>Brand Name</th><th>Age where SA is required</th></tr><tr><td>Advair® Diskus2 50/50, & 500/50</td><td>Children < 12 years</td></tr><tr><td>Advair® Diskus 100/50</td><td>Children < 4 years</td></tr></table></td></tr>
<tr><td>*Foradil®
*Serevent Diskus®</td><td>*Arcapta Neohaler®
*Brovana®
*Perforomist®</td></tr>
</table>

Preferred Agents	Non-Preferred Agents	SA Criteria
		Advair® HFA — Children < 12 years *Anoro™ Ellipta* — Children & Adolescents < 18 years Arcapta® Neohaler — Children & Adolescents < 18 years Brovana® — Children & Adolescents < 18 years Dulera® — Children < 12 years Foradil® Aerolizer — Children < 5 years Perforomist® — Children & Adolescents < 18 years Serevent® Diskus — Children < 4 years Symbicort® — Children < 12 years
Short Acting Metered Dose Inhalers or Devices		
Proventil® HFA	*Maxair Autohaler* *Proair® HFA* *Ventolin® HFA* *Xopenex® HFA*	
Short Acting Nebulizers		
albuterol sulfate all premix **metaproterenol** **Xopenex®**	*levalbuterol soln*	
COPD: Bronchodilators and Phosphodiesterase 4 (PDE4) Inhibitors		
Atrovent HFA® **Combivent® MDI** **Combivent® Respimat** **ipratropium bromide soln** **ipratropium/albuterol nebs** **Spiriva®**	*Anoro™ Ellipta* *Daliresp®* *Duoneb®* *Tudorza™*	**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edit plus** **Clinical Criteria for Daliresp®** • If the patient has a diagnosis of severe COPD associated with chronic bronchitis and a history of exacerbations and • Trial/failure on at least one first-line or second-line agent (inhaled anticholinergics, long acting beta agonists or inhaled corticosteroids) and • Adjunctive therapy (Daliresp® must be used in conjunction with first-line or second-line agent)
Corticosteroids: Inhaled and Nasal Steroids		
Inhaled Corticosteroids: Combination Products (Glucocorticoid and Long Acting Beta Adrenergic)		**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit**
***Advair® Diskus & HFA** ***Dulera®** ***Symbicort®**	*Breo® Ellipta™*	

Preferred Agents	Non-Preferred Agents	SA Criteria
Inhaled Corticosteroids: Metered Dose Inhalers		
Asmanex® **Flovent® Diskus & HFA** **Pulmicort Flexhaler®** **QVAR®**	*Alvesco®* *Aerospan™*	
Inhaled Corticosteroids: Nebulizer Solution		
Pulmicort® Respules	*Budesonide*	
Nasal Steroids		
Nasonex®	*Beconase AQ®* *Dymista™* *Flonase®* *flunisolide* *fluticasone* *Nasacort® AQ* *Nasarel®* *Omnaris®* *Qnasl™* *Rhinocort Aqua®* *triamcinolone acetonide* *Tri-Nasal®* *Veramyst®* *Zetonna™*	
Cough and Cold products		
Drug Name and *GNN*	*All other Legend cough*	**LENGTH OF AUTHORIZATION**: Date of Service only
Ala-Hist DM *brompheniramine/ phenylephrine/ dextromethorphan*	*and cold products are non-preferred* *Tessalon ® perle*	**Routine PDL edit**
benzonatate cap **codeine/ promethazine** **Carbatuss-12®** ***Carbetapen cit, carbetap tan, PE HCL PE Tan*** **guaifenesin/codeine phosphate**		**Clinical Edit for Cough and Cold Agents – All children under 6 will not be eligible for cough and cold products.**

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	hydrocodone/ homatropine iophen-C NR *guaifenesin/codeine phosphate* **Lohist-DM syrup** *brompheniramine/ dextromethorphan/ phenylephrine* **phenylephrine HCl/promethazine HCl** **poly hist DHC** *pyrilamine/ phenylephrine/ dihydrocodeine* **poly-tussin DHC** *brompheniramine/ phenylephrine/ dihydrocodeine* **promethazine DM syrup** **Tusnel® Pediatric Drops** *dextromethorphan/guaifenesin/pseudoephedrine*		
	Intranasal Antihistamines		
	Astepro® 0.15% **Patanase®**	*azelastine 0.1%*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit**
	Leukotriene Receptor Antagonists		
	Accolate® **montelukast tabs/chew tabs/granules**	*Singulair® tabs/chew tabs/ granules* *zafirlukast* *Zyflo™* *Zyflo CR™*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit**